HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Methylphenidate hydrochloride

INITIATION – ADHD (immediate-release and sustained-release formulations)

Prerequisites (tick box where appropriate)

- ❍ Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria

INITIATION – Narcolepsy (immediate-release and sustained-release formulations)

Prerequisites (tick box where appropriate)

- ❍ Prescribed by, or recommended by a neurologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient suffers from narcolepsy

INITIATION – Extended-release and modified-release formulations

Prerequisites (tick boxes where appropriate)

- ❍ Prescribed by, or recommended by a paediatrician or psychiatrist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ❍ Patient has ADHD (Attention Deficit and Hyperactivity Disorder), diagnosed according to DSM-IV or ICD 10 criteria

and

- ❍ Patient is taking a currently listed formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties

or

- ❍ There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

I confirm that the above details are correct:

Signed: ..... Date: .....